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COMPLUTENSE

Loneliness and conflicts in hospitals: An outlook from the field of social work, the ethics of care and the discharge planning for dependent elderly people

Joan Casas-Martí[1]

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Abstract. Hospitals are places where the precariousness of social ties can turn into loneliness, especially in those moments in which a (greater) need for social care cannot be satisfied. This paper presents the results of a qualitative study that has used the techniques of the systematisation of experiences and in-depth interviews with professionals in medicine, nursing and social work from different geriatric hospital services. The purpose has been to reflect on the family model of care as a producer of loneliness in elderly people in a situation of dependency, as well as on the multiple and varied conflicts that this loneliness generates in the planning processes of hospital discharge. The role of social work is identified as essential to overcome the lack of care that underlies the phenomenological manifestations of these kinds of loneliness. The main conclusions reached are added to other voices that have already urged the need to (re)think our care model, as the current one is not only obsolete and insufficient, but has been built on the (re)creation of inequalities.
Keywords: Loneliness, aging, dependency, hospital discharge planning from hospital, social work.

[es] Soledades y conflictos en los hospitales: Una mirada desde el trabajo social, la ética del cuidado y la planificación del alta con personas mayores en situación de dependencia

Resumen. Los hospitales son escenarios donde la precariedad de los vínculos sociales puede convertirse en soledad, especialmente en aquellos momentos en los que emerge una (mayor) necesidad de cuidados sociales que no puede ser satisfecha. En este trabajo se presentan los resultados de una investigación de carácter cualitativo que ha hecho uso de las técnicas de la sistematización de experiencias y la entrevista en profundidad a profesionales de la medicina, la enfermería y el trabajo social de diferentes servicios hospitalarios de geriatría. El propósito ha sido el de reflexionar en torno al modelo familista de cuidados como productor de soledad en personas mayores en situación de dependencia, así como en torno a los conflictos de múltiples ejes que esta soledad genera en los procesos de planificación del alta hospitalaria. El rol del trabajo social se identifica como primordial para superar las lógicas de desamparo que subyacen en las manifestaciones fenomenológicas de estas soledades. Las principales conclusiones a las que se llega se suman a otras voces que ya han alertado de la necesidad urgente de (re)pensar nuestro modelo de cuidados, en tanto que el actual no solamente es obsoleto e insuficiente, sino que se ha construido sobre la (re)producción de desigualdades.
Palabras clave: Soledad, envejecimiento, dependencia, planificación del alta hospitalaria, trabajo social.

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[1] casasmarti@ub.edu
GRITS - Universitat de Barcelona
https://orcid.org/0000-0003-2376-0347

1. Introduction

Loneliness is a multifaceted concept that has been interpreted from different theoretical approaches and is often seen as the subjective counterpart of the objective measure of social isolation (Yanguas et al., 2018). However, loneliness becomes apparent within the framework of an underlying social order (Martínez-Palacios, 2020), and it is essential to recognise it in order to avoid turning it into an individual problem or distorting its political and social dimension.

This paper discusses the loneliness of some elderly people in a situation of dependency that arises in the process of hospitalisation as one of the manifestations of the crisis of the care model[2]. An ethnographic exercise carried out on the basis of my Master's thesis concluded that those health-illness processes that lead to hospital admissions in which some elderly people see their functional capacities weakened, become a context in which loneliness becomes evident (Casas-Martí, 2021), as their situation of (greater) dependency requires *someone* who they do not have or someone they do have but does not have the necessary resources to be able to care for them. This, in turn, shows that the Mediterranean care model, based on family solidarity (Daly & Lewis, 2011), is totally insufficient, since apart from relying on a framework that reproduces women's social inequality, it extends loneliness in the insufficient provision of public assistance, austericide and the commodification of care (Comas d'Argemir, 2014; 2019).

In this sense, the conflicts surrounding the loneliness of hospitalised dependent elderly people are not only due to the personal implications in phenomenological terms and felt and experienced abandonment, but also to the gap that exists when planning the hospital discharge of patients[3] in a situation of dependency without a family that can care for them, often with class impediments to access the service market and in the midst of a socio-political context marked by the devaluation of care.

Social work –historically– started from the premise that the lack of significant relationships affects people's quality of life, the possibilities of receiving support and feelings of belonging to the community. Since the beginning of the discipline, *interdependence* has been talked about as one of the central conceptual axes (Richmond, 1922), an issue that comes into conflict when we talk about loneliness. Feminisms recovers this issue, making emerge, among other postulates, the *ethics of care*; a moral perspective that is based on the responsibility one has towards others (Gilligan, 1982). This contribution, and those that have followed, understand that life is not possible without reciprocities, providing new interesting elements for the practice of social work (Cubillos, 2014) and, specifically, to think about social work in the care of loneliness (Casas-Martí, 2021).

2. Objective and methodology

This article uses a qualitative approach to reflect on discharge planning processes, in which social workers often come into play (Colom, 2000) in the context of the abandonment that gives meaning and significance to the loneliness manifested in hospitalisation processes. For this purpose, the fieldwork, carried out in the city of Barcelona (Spain), consisted of two stages in which different techniques were used:

A first stage lasting one year, from February 2019 to February 2020, which was based on the systematisation of experiences (Jara, 2012; Rodríguez, 2019) derived, *from the inside*, from my professional activity as a social worker in the field of study. This has included the completion of a field diary without a prior categorical framework, in order to dynamize intellectual production (Expósito & González, 2017). In no part of the process was any data of a personal or particularly sensitive nature collected (and therefore not recorded), but rather reflections on my professional experience in relation to loneliness that have allowed me, subsequently, to make an exercise of abstraction for the dialogue with the technique used in the second stage.

A second stage lasting eight months, between February and September 2020, in which I was no longer on the field ground, coinciding with the end of my working relationship with the hospital where I had been. *From the outside*, five in-depth interviews were conducted with medical, nursing and social work professionals from different geriatric hospital services in the city of Barcelona. This stage was also characterised by the outbreak of the health crisis caused by the Covid-19 pandemic, which is why the interviews had to be conducted on-line, given the impossibility of being physically present and the mobility restrictions imposed by the state of emergency.

The interviews were recorded and transcribed to facilitate their subsequent analysis, which was carried out by coding them with the support of the Atlas-Ti programme. The sampling strategy was snowball sampling (Brunet et al., 2002). All interviews were carried out after having informed the participants of the purposes of the study, as well as after receiving their consent. Based on a pseudonymisation, I will refer to the interviewees

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[2] The crisis of the care model has been defined as what arises in a context in which the increase in demand for care (the result, for example, of an ageing population) is not accompanied by an increase in supply. The lack of socialisation of care, and the insufficient public response to it, leads to a re-familiarisation and re-feminisation of care, reproducing social inequalities such as those of gender and class (Pérez-Orozco, 2006).

[3] In some cases, and in order to approximate to *emic* hospital nomenclatures, the term *patient* or *sick person* will be used to refer to hospitalised persons.

as Cori (medical doctor or MD); Anna (nurse); and Veronica, Mia and Claudia (social workers or SW). All of them had more than ten years of experience in their professional practice, except Mia, who had two years of experience. The reason why greater weight has been given to the contributions of social workers is not only due to a certain professional deformation; it is due to the fact that social work is a profession which, due to its care role, works *face to face* with loneliness (Hagan, 2021), being a figure of accompaniment and, specifically in the hospital setting, a link with the community and with the resources for the care of people in a situation of dependency (Colom, 2000).

3. Results

3.1. Discharge planning

The often-abrupt change in patients' needs during admission forces hospitals to establish discharge planning procedures that, in many cases, begin a few days after admission (Casas-Martí & González, 2019). Dolors Colom appeals to the social planning of hospital discharge as an antidote to the vicious circle that occurs when, during admission, priority is given to the treatment of the organic problem, ignoring any possible difficulties at the time of discharge (Colom, 2000). This vicious circle also tells us that, when discharge is announced, the patient him or herself then expresses his or her inconvenience, prolonging the hospital stay until the team persuades him or her to return home and *leave* his or her bed free. Consequently, and in view of his or her unfavourable and *poorly worked* social situation, his or her state of health worsens, and the patient is forced to be readmitted.

> Nowadays, there is interdisciplinary work in hospitals. When there is an illness that becomes chronic and generates dependency, the objective is to know how the person's situation was before the illness and to see in what situation the person finds him or herself relationally and socially at the time of admission. The idea is to acknowledge the before and after. How is the person? How does the illness affect their relationships? What is the relationship with the family after the illness? What support capacity does the family have? [...] At the end of the day, we are looking for the resources available to them to see if they are sufficient to guarantee the care they will need at the time of discharge (Verónica, SW, interview).

In this context, discharge takes on a strong symbolic power, insofar as it is the return to the patient's usual environment, which often does not have the capacity to care for him/her (Allué, 2013). During the hospitalisation process, the patient must deal with the illness and with making immediate decisions: adapting their home, moving into a nursing home, hiring a family worker, etc. The processes of acceptance of a new situation of dependency and lack of support do not keep pace with hospital admissions, establishing a very significant time lag; there is increasing pressure on professionals to discharge people as soon as possible and making admissions more economically efficient (Ceballos et al., 2014). People without a social or familial network that responds to their care needs may be problematic for hospital institutions, as they do not have access to the main source of care provision in our society.

> I had a case of a man who broke his leg. We began to investigate and found that he had no one. He was a man who lived in the harbour neighbourhood of Barcelona and had nobody. [...] So the question was: What do we do now with this man? Where do we refer him? Where do we take him? [...] Who will take care of him? Who guarantees that this man is fed and hydrated? Who will support this? (Claudia, SW, interview).

In these resource-seeking, *problem-solving* procedures, the patient is treated as an anomalous body (vulnerable, dependent) in contrast to a normative body (healthy, independent). Care is configured as a relationship between two (caregiver/dependent) without recognising the possibility that the same person can offer and receive care at the same time (Tronto, 2013). The medical doctor I interviewed spoke to me precisely about the refusal of some patients to accept their changed functional situation. Some want to go home and refuse any kind of support, regardless of the certainty that their health is at risk: "If they are clinically stable, nothing can be done. There are patients who have a lot of underlying comorbidities and want to go home". Lola, who she referred to, was a 97-year-old woman who lived alone and had no family. She came to the hospital because she had fallen. Neighbours saw that she did not open the door and called the fire brigade. They found her lying on the floor, where she had been for many hours: "You see this lady I treated, with a lot of cardiac and intestinal pathologies, with a lot of medication, and as a medical doctor you can't imagine how she can be alone". This fall was evidence of Lola's fragility and the risk of further falls was very high. However, she wanted to go home, and would not accept any kind of support:

> The social worker and I spent a lot of time insisting, but we couldn't get her to accept any kind of help. [...] She is a lady who was getting worse and worse functionally and had no one, but she has no cognitive impairment

> and legally we can only coordinate with the primary care social worker so that they know this situation (Cori, MD, interview).

In the discharge planning process, the patient passes through the hands of many professionals (Colom, 2000). The medical team, the nursing team, social work team, etc. In many cases the patient does not yet have a reference professional with whom he or she can work the end of the hospital stay. A former teacher, with whom I shared some ethnographic notes, made me reflect on this question, narrating it to me as a kind of secondary victimisation that deepens the unwanted loneliness of some hospitalised elderly people: *Who will be your companion throughout this journey? Who will be that face you can trust? Who will support your abandonment?*

3.2. Prolongation of stay: An economistic perspective

Far from putting care at the centre, there is often an economistic discourse (Carrasco, 2003) of hospital activity on behalf of management and, from a kind of *alienation*, also from a part of health professionals. One of the questions I asked myself when immersed in this logic was whether loneliness can become a *problem*, in economic terms, for institutions. There is a general guideline to optimise hospital stays by adjusting them strictly to the time required for certain treatments for certain medical conditions.

> A day in a hospital is very expensive. The pressure we have to discharge [patients] is very important. People who don't have any kind of treatment to do, are in hotel mode and of course doesn't make any sense. [...] The budgets that exist are getting tighter and tighter. In Catalonia, since 2010-2011, budgets have been cut and there is less and less staff. The less time the person is in hospital the better, the less expense the better (Verónica, SW, interview).

Different studies show how there is a correlation between the socio-familial situation and the number of days spent in hospital (Ceballos et al., 2014). Having no family and being alone, for example, is correlated with increased days of hospitalisation. Before starting the fieldwork for this research, a colleague and I took the opportunity to quantify the social risk of patients in a geriatric unit (taking into account variables such as family situation and relationships or social support) and the days of hospitalisation, finding that those with an intermediate or high social risk had spent more days in hospital, on average, than the others (Casas-Martí & González, 2019). It is also relevant that older patients tend to have longer hospital stays (Ceballos et al., 2014). The need to plan for the discharge of *isolated persons*, and the insufficient public care assistance, have a serious impact on the economic efficiency plans of acute-care units in hospitals. Some geriatric services, often located in intermediate hospitals, are more flexible, as patients often have to reorganise their lives in terms of care provision. On the other hand, the medical doctor interviewed pointed out that the prolongation of the hospital stay of patients in a situation of loneliness may also be due to the fact that the physician wants to ensure compliance with certain therapeutic procedures, that an accompanied person could do at home.

> As a medical doctor, you are sure that if you discharge a patient with a family early, they will comply with the medication, and that if there is an alarm signal, the family will take them to the emergency services. [...] With isolated patients, you are not sure if they will take the antibiotics or if they will comply with the instructions you have given them. So you are more cautious and discharge them when they have finished the treatment or when you have already corrected certain analytical alterations. [...] This means that the patient who is alone is hospitalised for more days (Cori, MD, interview).

One of the social workers interviewed, Mia, also stressed that, beyond isolation, what causes prolonged hospital stays is the slowness of the social services to respond to emergency situations. The inability to wait for the activation of certain social resources for dependency care leads to premature discharges, increasing the risk of clinical destabilisation and readmission:

> Discharges are medical, not social, and this means that sometimes they are given early, without working on the social side. [...] What happens is that after a few days or hours [the patient] is readmitted because the support they need has not been guaranteed (Mia, SW, interview).

Mia also referred to the pressure on social workers to speed up the availability of resources: “Some of the staff don't understand that we can only wait, we have a lot of people on top of us”. However, some prolonged hospital stays, especially in the so-called *socio-health centres*, have given rise to experiences reminiscent of the old asylum function of the old poor hospitals (Comelles et al., 2017). Verónica explained to me the case of a man who had spent years in a long-stay unit waiting for a place in a nursing home: “He was a man who didn't have a home, he was *homeless*. He was in a wheelchair and was in the long-stay [intermediate hospitalisation unit] like a hotel”. And she added: “some nursing homes take a long time to admit you and the administration knows that as long as this man is in a socio-health care facility we won't throw him out”.

3.3. 'I'm fine here' or 'I'm not taking him/her home like this'

The conflict generated by loneliness in hospital institutions has to do with the hindrance posed to the biomedical logic by the care crisis and the failure of the public care system (Comelles et al., 2013). The ally of the health institution, the family that has always taken care of the sick, is increasingly less present (Pérez-Orozco, 2006), and this represents an immediate problem for hospitals, and a socio-political challenge. This is undoubtedly one of the effects of not putting care at the centre of a public system which, theoretically, should look after our health. The vicious circle of hospital discharges (Colom, 2000) discussed above precisely speaks of the social problem of discharge as a kind of strange variable in an environment in which bodies have traditionally been separated from the social dimension of people (Allué, 2013). Institutionally, hospital resources continue to be configured considering the *body* solely as an *organic body* separated from its socio-cultural environment, contrary to the narratives of health professionals, especially in geriatric services. Balazs (1999), in Bourdieu's *La misère du monde*, presented the interview he conducted with Lousie, a hospitalised elderly woman who had no family caregiving environment. Lousie raised the question of who would take care of her once she was discharged from hospital. The discomfort that brought her to a hospital emergency room made visible an isolation that, until then, had gone unnoticed. In short, the conflict caused by loneliness in hospitals takes many forms. On the one hand, the emergence of a painful feeling in those for whom isolation had never been a problem before. On the other hand, for the institution, insofar as reluctance to discharge appears, it jeopardises the efficiency that today's hospitals claim to have (Comelles et al., 2013).

> Often patients do not want to leave. There are people who are used to having everything done for them in the hospital. [...] There are people who don't want to leave because they are afraid. They were autonomous people and now they need help and they realise that they have no one (Mia, SW, interview).

'I am fine here' refers to the reluctance to discharge that comes from some elderly people who are alone. It is a statement that is made by the patient when the medical team begins to talk about the proximity of discharge. The hospitalised person is forced to face their loneliness and their new functional reality and dependency. The statement asks for time and expresses that they feel protected in the hospital. Health professionals refer to '*hospitalism* risk' when a person asks to stay in hospital. It is a term that interested me, because it appeared repeatedly during my work experience. Hospitalism, as far as the patient is concerned, is a condition of dependency that steadily increases in a protected environment, until the institutional lifestyle displaces and overrides any participation he or she may have in the community (Ryan et al., 1982). Born out of psychiatry, it is heir to Erving Goffman's concept of the *total institution*, who speaks of the conditions of isolation and dependency of the sick in the old psychiatric hospitals, where they were prevented from all contact with the outside world and where absolute control was exercised over all the activities of the inmates, nullifying them of all privacy (Goffman, 1970). In the hospital, when we speak of the risk of hospitalism, we speak of those patients who are reluctant to be discharged as a means of avoiding the problems that await them outside the hospital. The ageing body is confronted with its general vulnerability, not being as it used to be. To think of the future is to think of decline and sometimes death.

A colleague at the hospital where I worked spoke of the difficulty for the patient of being dependent; something that, most of the time, even the family itself does not know how to cope with. Another of the statements I have heard in relation to reluctance to discharge comes from families who *give up*. 'I'm not taking him/her home like this' refers to the new functional situation of the patient and the manifest impossibility of the caregiver to continue in this role. When dealing with family members, you realise that they have often *abandoned themselves*; in order to care, they stop caring for themselves, something that has been reported in numerous research studies (Esteban, 2011). In addition, the recognition of *not being able to do so* is often experienced as abandonment by the patients and, often, by the health professionals, who, in occasions, are not participants in –or sufficiently aware of– a whole history of sacrifice and physical and emotional burden.

> Every day we see families saying 'enough' in geriatric services. Every day. Older patients with cognitive impairment that has developed, who are increasingly dependent on their families, and whose families are unwilling or unable to do so. When they arrive at the hospital, they leave the patient almost abandoned. They say: 'here he/she is'. [...] It always tends to be as a result of a small progression of the disease, *a straw that breaks the camel's back* (Cori, MD, interview).

From a logic that links care with affectivity, and with abnegation and renunciation, informal caregivers -mostly women- care out of love and solidarity, thus facilitating the emergence of negative emotions such as feelings of guilt, frustration or loneliness. Mari Luz Esteban, in a dialogue with Isabel Otxoa, said that, although it would be foolish to deny the importance of emotions in caring for others, this association, and the social construction that women are emotional beings, represents one of the main instruments of social subordination (Abasolo, 2010). Family claudication in a hospital context hides a desperate demand. Family members who give up are requesting the transfer of care to the health system, which cannot respond when there are no medical criteria for hospital admission, and is limited by the austerity of the public system of social services and dependency care (Comelles et al., 2013). It is also appropriate, therefore, to speak of the loneliness of the main carers, often the only ones and without support from other members of the family unit or the public system, who are often condemned to double exploitation, insofar their incorporation into the labour market is precarious and has not led to a redistribution of care work (Ezquerra, 2012), and whose despair leads them to go with their relatives to hospitals, places of socio-cultural reference, in the hope of obtaining a response.

3.4. And then what? Who takes care of you if you don't have a family?

A nun from the spiritual service of the hospital where I worked explained, in her book, that the pain and limitations that the sick person goes through call for *care* and *presence* (Puga, 2018). Although we are all providers and recipients of care throughout our lives, our capacities and needs vary over time (Tronto, 2013). In hospitals there are people who are at a time of great need, and people who are alone have no one with greater or lesser capacity to care for them. As developed above, the care crisis arises precisely with the increase in demand and reduction in the supply of care (Pérez-Orozco, 2006). Intergenerational reciprocity threatens to disappear as women in the family gradually cease to be its main actor. Additionally, there is little support from public policies for people in a situation of (increased) dependency. The lack of emphasis on family solidarity exercised by women within a care model based on this model places us in a scenario in which a significant number of elderly people must and will have to turn to other care provision systems (Bofill-Poch, 2018). The loneliness of the hospitalised patient highlights this issue, as well as the urgent need for transformation.

> The way to give value to and redistribute all the work does not lie in demanding that society recognises how much it owes us women; it lies in the individual and collective refusal to continue covering care needs as we do today. Only through an active position of resistance, of contestation, of standing up to an obligation that contributes to our discrimination, will we be able to turn the current situation around (Abasolo, 2010, p. 9).

In cases where *alone people* have a good financial capacity, the situation of loneliness is not seen as problematic by hospitals, as the market increasingly establishes itself as a major provider of care (Izquierdo, 2003). However, some older people have saved all their lives and find it difficult to make the decision to devote their money to providing the support they need. This brings up the feeling of injustice that Bofill-Poch (2010) speaks of towards the neglect they suffer from the long-term care system: *All my life I've been paying social security contributions and now I have to pay two thousand euros a month for a nursing home?* –I was told by angry patients after having to inform them that they were not entitled to a public benefit because of their financial capacity. In addition, private resources for dependency care hide a hodgepodge of stories of precariousness and exploitation, having come to depend on migrant women, framing them in the underground economy, or in a regularisation based on bureaucratisation and precariousness (Briones et al., 2014).

> In case there is no one who can take care, the first thing that is looked at is whether the patient has financial resources or not. [...] If a person is alone and dependent, but has money, there is still vulnerability, but it is not so serious. They can easily hire a carer or pay for a nursing home (Mia, SW, interview).

Hospitals usually have information on private residential resources or home care service companies. Some residences close to hospitals establish informal collaboration agreements with referring professionals. Some elderly people prefer to hire the services of a company recommended by a hospital professional rather than a company that they find themselves, one of my informants told me. While institutional care, especially residential care, has traditionally been interpreted as neglect, some authors point to a progressive change, in terms of less stigmatisation, of the current social imaginary towards residential institutions[4] (Barroso et al., 2016). However, it is common to see how people who have been living alone for years get used to this dynamic and do not easily accept an external resource. This is what Anna, the nurse interviewed, told me: "People tend to be alone and do things their own way. When we propose home help, they reject it. To recognise that they need help is to recognise that they are old and fragile".

3.5. Who takes care of you if you do not have money? The lonely and precarious

Someone said that the strength of a society is measured by the value we place on our elders, and I would add, also, by how we care for people in a situation of (greater) dependency and vulnerability. Speaking of care in a narrow sense, and focusing on the socio-political interventions that take place in the context of the dependency of people who need care more than they have the capacity to provide it, vulnerability is accentuated when, in

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[4] It is possible that the side-effects of the Covid-19 pandemic may have affected this issue, although this will need to be analysed in the longer term.

addition to being elderly, alone and in a situation of dependency, hospitalised people are *poor* in economic terms. Dolors Comas d'Argemir wrote about the class injustice associated with care that «social inequalities affect health inequalities, and the most disadvantaged sectors age in worse conditions» (Comas d'Argemir, 2019, p. 20). In these cases of loneliness, not only does the main care provider - the family - fail, but there are also impediments to accessing the market, with public provision becoming the only option.

In hospitals, it is evident that the system of care for dependency –and the law that supports it– at the state level is absolutely deficient and obsolete, while dependency often arises from one day to the other and, as a matter of dignity and even survival, may require an urgent response. Social services, at municipal level, are configured unequally depending on where you live, are not preventive, and everything must go through a bureaucratisation that slows down the activation of resources. The centrality of care, and the ontological question that we are all, by definition, interdependent, is not accompanied by a socio-political position that recognises this, becoming an invisibilization that legitimises the scarce public intervention in these cases. Cristina Carrasco strongly criticises the fact that care for the elderly is discussed basically in terms of the high social cost and as a financial problem of pensions; the question is how we care for the elderly population, which involves far more resources than just the monetary resource of pensions. Furthermore, the author states that we have accepted that, once we have reached a certain age, we have to reduce our quality of life in terms that go beyond *natural ageing* itself (Carrasco, 2003, p. 4).

> The dependency law does not work well, many things need to be reconsidered. Dependency often arises from one day to the next and the dependency law takes at least a year. [...] What is it solving for me? There are illnesses that are progressive, that allow you to plan, but many others do not. A 2-hour care worker's help per week is of no use to a dependent person, and there are long waiting lists for residential homes (Mia, SW, interview).

From a feminist care ethics perspective, it is clear that we are facing a society that systematically devalues care. The moral qualities and skills associated with care are not, according to Tronto (2013), among the main ethical values of our society. Claudia explained to me that over the years she has been intervening, everything has remained the same: "The law on dependency created false expectations, the theory was fine, but in practice it has not been. What has happened here? The law does not look at reality, it is not on the ground, the situations are all unique". There are many elderly people who are below the poverty line and there is no dignified way of being able to accompany them: "In the end it is the professionals who end up deciding for these people. If the local council offers you a place in an urgent care home, you take it and don't consider anything else". And, in effect, this puts the fulfilment of the individual self-determination of the users, one of the most relevant values in the ethical theories that have guided, and should continue to guide, the praxis of social work, at profound risk (Cubillos, 2014).

A social worker told me that *alone people*, unlike accompanied people, will tend more to be institutionalised than to be able to return home. In Barcelona, there are the Services of Emergency Shelter for the Elderly (*Servicio de acogida de urgencia para personas mayores*, SAUV) where, occasionally, when there are situations of social abandonment, temporary admission to emergency residential centres can be requested (Ajuntament de Barcelona, 2022). There are residences that have agreements with the local government and that reserve public places for these emergency situations, although these are very scarce resources and, when they are requested, there is a whole process of assessment by the public administration that leads to the approval, or not, of the applications. These residences may be outside the city, which may *force* the user to leave the environment in which he or she has always lived, again giving rise to paternalistic actions or actions that are poorly protected by the ethical frameworks of the profession (Cubillos, 2014). What prevails in the hospital is urgency, but an *urgency* understood in a biomedical sense, while taking little account of its social and emotional repercussions.

> A person who is conscious and oriented knows what he or she wants in life, also at 97 years of age. [...] Who are you to tell her to go to a nursing home? [...] I believe that the great conflict is not knowing how to accompany loneliness without falling into paternalism. We fall into looking for the service, the mechanism.... I will have to decide for you or sometimes I will use manipulation to decide that you would be better off somewhere else. We lose sight of the most important thing, which is the life story of the people, and accompanying them in the will of what someone wants (Claudia, SW, interview).

Yusta (2019), reading the public resources for dependency care in relation to how they interact with the loneliness of the elderly, concludes that the law on dependency has a poor treatment of situations of loneliness. Speaking of the concept of *residential loneliness*, he pointed out that residential centres, against all odds, do not in any case ensure the reduction of feelings of subjective loneliness: «Although the person lives together with dozens of users in the same situation, he or she feels lonely and shows a large part of the symptoms of loneliness» (p. 33). On the contrary, the home care service is seen as a resource that can serve, to a certain extent, to make the user feel accompanied, although generally the number of hours established are usually insufficient and the person does not have contact with people with a similar profile to their own, but rather it is a professional-user relationship based on the allocation of the resource itself.

> Being admitted alone to hospital, staying in a socio-health care centre and then going to a nursing home. [...] What happens? That suddenly the person thinks: 'I was at home, with my things, and now here there are 25 more people like me, but I don't feel much more accompanied'. [...] Emotional bonds are complex to generate, and it is true that more and more residential centres are changing their *mindset*: 'This is not where people come to die, it is where people come to live their end of life'. This means that when someone comes in, I have to know who they are, what they want, what they don't want, what they like, what they don't like, and what their motivation is to help them in this process (Claudia, SW, interview).

The lack of public resources is collapsing hospitals, especially intermediate care hospitals, because there are no outlets, resources or benefits (Casas-Martí & González, 2017; Ceballos et al., 2014). Public resources are not keeping pace with health and dependency, and seem to live with their backs turned to a growing reality. The care crisis puts on the table that we need a change, an in-depth review of how we are doing things and how they can be done to make our lives better (Pérez-Orozco, 2006). Demanding that the state takes responsibility for care is also, according to some feminist debates on care, demystifying that family care is the ideal or only possible care (Comas d'Argemir, 2014). In this sense, Tronto (2013) argues for recommitting ourselves to care –for ourselves and others– by accepting and rethinking our responsibilities and providing sufficient resources for care: «If we are able to do this, we can improve levels of trust, reduce levels of inequality and provide real freedom for all» (p.182).

4. Final reflections

The qualitative approach carried out has revealed, in a hospital environment and in the current situation of crisis, the double conflict that makes the loss of autonomy emerge in some elderly people. On the one hand, the awareness of a kind of loneliness that speaks of absences and frustrated expectations. And, on the other hand, the difficulties of reorganising one's life that emerge when one does not have the support of those who –in the current family model– *are supposed to* offer it.

The lack of family to provide care in those cases in which the situation of autonomy-dependency is different from before hospital admission, obliges hospitalised persons and professional teams, during the discharge planning process, to seek other sources of care in order to ensure successful discharge, once the corresponding medical-health procedures have been completed (Colom, 2000). In an intersectional perspective, this is where different variables come into play, such as class. In cases where *alone people* have the economic capacity, they are oriented towards turning to the market to meet their care needs. This, beyond representing important changes in people's lives and perpetuating the sustainability of a model of commodification of precarious care, it is not seen as problematic in the eyes of the health institutions. The conflict that most (pre)occupies us appears when the elderly, *alone* and in a situation of dependency, do not have the possibility of contracting care through the market. Public provision is insufficient and, although the Dependency Act was a major effort to recognise the social dimension of care through a portfolio of resources for dependent persons, it was stripped of its content by the austerity resulting from years of economic crisis, becoming totally residual and insufficient (Pérez-Orozco & Baeza-Gómez, 2006). The elderly, *alone* and *poor* in economic terms, become, in hospitals, the most vulnerable population.

The current care model generates situations of loneliness and abandonment, as well as class and gender inequalities. The Covid-19 pandemic, and its effects, which are still difficult to calculate, has accentuated the instability and uncertainty inherited from the Great Recession of 2008, making evident the insufficient provision of social and dependency care resources, as well as their precariousness. Vulnerability characterises us all, and this implies, in the light of the feminist theorists who have accompanied us in the course of this paper, that the world is made up of relationships and that, therefore, we are subject of care rights and obligations. Loneliness challenges us because it is related to interdependence, to care, to our participation in the community and to the endowment of meaning and significance in our lives (Yanguas et al., 2018).

In short, this work has sought to alert us of the growing forms of loneliness that are gradually imposing and which have to do with the urgent need to reposition our priorities as a society: to place care at the centre, understanding that *life is not possible without others*. I also committed to a social work that claims its privileged and perfectly legitimate position for the study and visibility of (situated) social realities such as the one we are dealing with. In this way, I plan to continue a line of research that considers the phenomenon of loneliness as a fundamentally social phenomenon and that is oriented towards rethinking our professional role, avoiding the *medicalisation* of structural problems, and encouraging the incorporation of new axes of privilege-inequality in the analysis of the phenomenon (Martínez-Palacios, 2020). The approach to care, hand in hand with social work, can help to outline a longed-for ideal of freedom that does not lose sight of the fact that we depend on each other (Cubillos, 2014), and the ethics of care, together with that of social justice, must be the result of commitment, which implies an in-depth social transformation (Comas d'Argemir, 2019) that leaves no one *alone*.

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